LINKS ABA Therapy Behavioral Solutions

Client Admission Form

Client Name _____Date of Birth_____

Social Security #_____ Sex: Male / Female Client's Nickname _____

Home Address_____City/ State_____ Zip _____

Father's Name _____ Phone #_____

Father's Employer _____ Occupation_____ Work # _____

Email_____ Best way to be contacted: (circle) Phone/Email

Mother's Name _____ Phone # _____

Mother's Employer _____ Occupation_____ Work # _____

Email_____ Best way to be contacted: (circle) Phone/Email

Emergency Contact Name & Relationship_____Phone #_____

Primary Insurance_____ Policy # _____ Group # _____

Responsible Party/ Policy Holder: (All required) Name:_____

DOB_____SS# _____ Employer _____

Secondary Insurance _____ Policy # _____ Group # _____

Responsible Party/ Policy Holder: (All required) Name:_____

DOB_____SS# _____ Employer _____

****PEDIATRICIAN** _____

****OTHER TREATING PHYSICIANS**:_____

Client's Diagnosis _____ Age Diagnosed _____

Siblings of Client (#/names):

_____

_____

Please circle any therapies the applicant is currently receiving:

Speech Occupational Physical Psychological Other: _____

Is the client toilet trained? Yes / No On any special diets? Yes / No

List any medication the applicant is currently taking:

_____

_____

_____

If there are any special considerations we should know about please list them here and provide us with any documentation deemed necessary for those considerations:

_____

_____

_____

Check the services you wish for your child to receive below:

_____ Consultation/Intake _____ Assessment for Autism/Asperger's _____ ABA and/or VB Therapy

_____ Tutoring _____ Preschool/Learning Program _____ Other: _____

What Are Your Primary Concerns for Your Child?

_____

_____

_____

How did you learn about Links ABA Therapy? _____

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels.

I hereby request the use of the following confidential channels for the communications of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential communications I may have made.

1- May we discuss your Child's Personal Health Information with anyone else? (You must fill in the name and phone number if okay.)

_____

_____

LINKS ABA Therapy does not discriminate on the basis of disability type or level, sex, race, creed, nationality or ethnic background.

Diagnosis & Prescription for services must be received before services can begin for all insurance based clients. LINKS ABA Therapy holds the rights to release any client at any time due to extreme situations that may endanger the health or safety of staff or others.

I have read the above statement and understand LINKS ABA Therapy Policy.

Parent/Legal Guardian's Signature _____ Date _____

LINKS ABA Therapy, LLC
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Lake Charles< LA. 70607
337-377-6206